Figure 1. Aortogram performed from the right brachial route demonstrating a pseudoaneurysm of the proximal descending aorta just distal to the origin of the left subclavian artery. There is no extravasation.

cated, a clamp-and-sew technique might be a reasonable alternative, as suggested by Trachiolis and associates.[4] In a selected group initial nonoperative management and stabilization with β-blockers while other comorbidities are addressed, followed by elective repair, might be a reasonable option.

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References

1. Cook J, Salerno C, Krishnadasan B, et al. The effect of changing presentation and management on the outcome of blunt rupture of the thoracic aorta. *J Thorac Cardiovasc Surg*. 2006;131:594-600.
2. Kouchoukos NT, Bavaria JE, Coselli JS, et al. Guidelines for credentialing of practitioners to perform endovascular stent-grafting of the thoracic aorta. *J Thorac Cardiovasc Surg*. 2006;131:530-2.
3. Karmy-Jones R, Hoffer E, Meissner M, et al. Management of traumatic rupture of the thoracic aorta in paediatric patients. *Ann Thorac Surg*. 2003;75:1513-7.
4. Trachiolis GD, Sell JE, Pearson GD, et al. Traumatic thoracic aortic rupture in the paediatric patient. *Ann Thorac Surg*. 1996;62:724-31.

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Reply to the Editor:

We appreciate the kind comments made by Dr Murala and colleagues, and we agree with the operative technique and indications they describe. They have highlighted an ongoing issue with respect to managing traumatic aortic disruption in a patient who has not finished growing. Not only do late complications of erosion need to be considered, but we wonder whether the stented aorta will be prevented from growing, leading in later life to possible coarcation physiology. Thus as we and others have noted, endovascular approaches to this problem need to be incorporated into an algorithm that includes open repair, medical management, or both. We would argue that endovascular stenting be considered if there are contraindications to operative repair and to medical management (recognizing that different surgeons and centers might vary in what is considered a contraindication). Furthermore, because the vast majority of pediatric patients will be candidates only for cuff extenders or contralateral limbs, these should be used only if they can be applied predominantly on the "straight" portion of the descending aorta (to minimize endoleak) and if the proximal points of endografts are not so close to the left common carotid artery that any subsequent operation would require an anterior arch approach.

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I am afraid of using aprotinin because they say so?

To the Editor:

Cardiothoracic surgeons have become more aware of the worse outcomes associated with aprotinin after cardiac surgery, as discussed in the article by Mangano and colleagues[1] published in the *New England Journal of Medicine*. It remains an observational study that, as the authors point out, is in need of randomized studies. The main concern of the authors that has not been addressed is the analysis of a larger sample size in the aprotinin group compared with that for other antifibrinolytics. The weighted average effect of a large sample size can have a larger effect when outcomes are analyzed.

I will address further potential confounding factors by Mangano and colleagues.[1] The authors did not control for preoperative hemoglobin count. Zindrou and associates[2] reported on a cohort of 2058 patients and demonstrated that a preoperative hemoglobin concentration of 10 g/L or less had a 5-fold higher in-hospital mortality rate after coronary artery bypass grafting mortality rates seen in those with a higher hemoglobin concentration, despite having had blood transfusions. Maintaining a patient's hematocrit value within the normal range and avoiding extremes is important. The main surgical factor that affects outcome in coronary artery bypass grafting is anastomosis of the internal thoracic artery to the left anterior descending artery. Moreover, the absence of critical disease in other vessels also affected outcome.[3] Mangano and associates[1] also provided no information about the mean number of grafts per patient, perioperative blood loss, blood-saving techniques, and "transfusion trigger." These issues are important because there is a dose-dependent association between blood transfusion and the development of severe postoperative infection and death in patients undergoing cardiac sur-